scientific articles appearing elsewhere in this issue of the *Journal*. We submit that possibly medical schools might contribute by increasing emphasis on career planning via symposia and visiting lecturers. Indeed, the National Medical Association would be in a position to study these problems at committee levels. It is our sincerest desire at Homer G. Phillips to continue to expand all modalities of postgraduate training and to serve as an important training area for medical graduates without regard to race or national origin.

EDWARD B. WILLIAMS, JR., M.D.

LITERATURE CITED

1. WILLIAMS, E. B., JR. Guest Editorial, Resident Physician, v. 6, p. 76, 1960.
2. DAVIDSON, C. S. Editorial, Arch. Int. Med., v. 108, p. 169, 1961.
3. GLASER, R. J. Medical Care in Education in Hospitals Without Internes or Residents, J.A.M.A., 176:835-838, 1961.

RANN HOLDS IMHOTEP PLANNING MEETINGS

DR. EMERY L. RANN of Charlotte, N. C., held planning meetings for the Sixth Imhotep National Conference on Hospital Integration on October 7 and 8, 1961, in Charlotte. Dr. Rann, a past president of the Old North State Medical Society, is chairman of the Sixth Conference which will be held on Friday and Saturday, May 25, 26, 1962, at the Fifteenth Street Presbyterian Church in Washington, D. C., of which the REV. ROBERT PIERRE JOHNSON is minister. The Conference is sponsored jointly by the National Medical Association, the National Association for the Advancement of Colored People and the National Urban League.

Two planning sessions were held in Charlotte. The first was at the home of DR. RUDOLPH WYCHE, a member of the Council on Medical Education and Hospitals of the National Medical Association. Here DR. W. MONTAGUE COBB, chairman of this council and founder of the Conference, led an orientation discussion on the Imhotep purposes and approach. In attendance were DR. PHILIP NAUMOFF, president of the Mecklenburg County Medical Society; DR. JAMES HEMPHILL, a past president of this Society; DR. RAYMOND WHEELER, Charlotte internist; DR. RUFUS P. PERRY, president of Johnson C. Smith University; DR. LEROY R. SWIFT of Durham, N. C., a past president of the Old North State Medical Society; DR. JOSEPH L. BUTLER, DR. ROY WYNN, DR. ROBERT GREEN, DR. WYCHE and DR. RANN.

Attending the session, which was held at the Club Excelsior, were MR. KELLY ALEXANDER, a member of the national Board of Directors of the NAACP and president of its North Carolina Conference of Branches; DR. REGINALD HAWKINS, local dentist and civic leader; DR. ESSEX NOEL of Greensboro; DR. JAMES SIMMONS of Sanford; DR. LEROY SWIFT of Durham; DR. ROY WYNN, DR. ROBERT GREEN, DR. GEORGE LOWE, DR. COBB and DR. RANN.

THE IMHOTEP APPROACH

The significance of the selection of the name Imhotep, meaning, "He cometh in peace," was explained to the guests from the Mecklenburg County Medical Society. To seek the correction of entrenched justice by prolonged controversy and litigation is an obvious waste of time, energy, emotional tension and money, if the end can be attained by a meeting of minds. It has been the constant aim of Imhotep to effect solution of problems by this method. The success of prolonged negotiation for the admission of Negro physicians to the Medical Society of the District of Columbia was cited as a case in point.

However, the meeting of minds is often not easy to achieve. Every major agency or organization with responsible power in relation to hospital policies and operations was invited to send representation to the first Imhotep Conference in 1957. Many did so. But the American Protestant Hospital Association and the Catholic Hospital Association of the United States and Canada specifically declined to send representatives. Thus, the two organizations which symbolized the Christian ethic in relation to hospitalization did not in this instance agree to sit down to discuss the problem. Therefore, it is necessary to pursue the goal of eliminating racial discrimination in hospital affairs by additional means. Some other approaches have already been made.

In Wilmington, N. C., a suit was filed against a hospital in that community by three Negro physicians who sought admission to the hospital's staff in 1956 and reinstituted in 1961.

In Chicago, Illinois, ten Negro physicians in February 1961 sued 56 hospitals and five hospital organizations alleging that failure of Negro physicians to obtain staff appointments in Chicago hospitals involves monopoly in violation of the Sherman Anti-Trust Act. This suit is pending.

In New York City formal recommendations based on actual surveys urging the appointment of Negro physicians to hospital staffs have been made by the Medical Society of the County of New York and the Hospital Council of Greater New York. This procedure has had little effect. Similarly based recommendations have emanated from comparable auspices in Chicago with comparable lack of result.

The root of the evil in the exclusion of Negro physicians from the staffs of new hospitals built with the aid of Hill-Burton funds in localities where discrimination is the policy lies in the "separate but equal" clause of the Hospital Survey and Construction Act itself. Hitherto this provision has been regarded as impregnable but competent legal minds have indicated that this is not the case.

In the article following in this issue of the *Journal,* bases for attack on the constitutionality of this provision are outlined. Hence, two avenues must be pursued in this area. The one through the courts on the unconstitutionality of the "separate but equal" provision in the Hill-Burton Act; the other through legislation so amending the Act that the practice of discrimination in hospitals built with Federal aid will be outlawed.

In Illinois, legislation has been enacted depriving private volunteer hospitals of tax-exempt status when it can be proved that any patient has been excluded from admission because of race. This law has not proved very useful because of the difficulty of making a case. Imhotep must address itself to all of these approaches as well as any other possibilities which may exist.

THE NEGRO PHYSICIAN IMAGE

MR. KELLEY ALEXANDER as a layman, emphasized the invidious effect on the public mind produced by the restriction of Negro physicians to separate hospital facilities which were aged, obsolete, and poorly equipped. This makes the Negro patient regard the Negro physician as inferior and makes him seek hospital care from white auspices where he was likely to be shabbily treated. This false image of the Negro physician, it was stated, tends to be heightened by disparaging attitudes on the part of white physicians toward their Negro colleagues of whom they have little knowledge and with whom they have little communication. DR. ESSEX NOEL agreed to prepare a definitive statement on this topic.

Since population increases faster than doctors can be graduated, it is obvious that the concept of physician-population ratios on a racial basis is obsolete, being impossible of achievement in fact and un-American in concept. Hence, the speedy removal of race as a factor in any aspect of hospital care has to be the fundamental goal.

INVENTORY OF DISCRIMINATORY PRACTICES

It was generally agreed that a new inventory of discriminatory practices in relation to hospitals was needed. Dr. Rann presented a proposed form for a questionnaire which would produce the required information if replies were secured on a nationwide basis. It was decided that after revision in accordance with any suggestions received this questionnaire would be mailed first to the membership of the National Medical Association.

Subsequently, this questionnaire or one suitably modified would be sent to the local community Imhotep Committees, as they are organized, and also to the Women's Auxiliary of the National Medical Association for the further gathering of data.

The findings from all sources would be published in the March 1962 issue of the Journal of the National Medical Association if received not later than January 25, 1962. In addition the findings of a number of separate surveys and reports now known to be in progress would be similarly published in the January or March issues of the *Journal,* if made available in time. Thus delegates to and guests of the Sixth Imhotep Conference would have for advance study all relevant information it had been possible to collate.

In addition, the editor of the *Journal* pointed out that it might be practicable to make available in brochure form a summary of all developments since the first Imhotep Conference in 1957. Such a brochure could be distributed at cost at or prior to the 1962 Conference. Developments up to March 1957 had been reported in the Proceedings of the 1957 Conference, together with a comprehensive bibliography. A few copies of these Proceedings are still available.

IMHOTEP COMMITTEES

A basic tenet of Imhotep from the beginning has been the mutual identification of the interests of the people, as patients, and the healing professions with each other. It was for this reason, when the Conference was conceived and organized in 1956, that the National Medical Association sought and secured alliance with the NAACP as a co-sponsor. This relationship was later expanded to include the National Urban League. In the Imhotep hospital integration effort, therefore, professions and public stand inseparably united.

The importance of this unity cannot be overemphasized because the public has obtained an opposite image of the profession from the activities of the American Medical Association and the expenditure of untold thousands of dollars by that organization for public relations has not served to counteract the public impression of selfishness on the part of physicians. Imhotep, in starting out as a joint effort has achieved a sense of unity and common interest which money cannot buy.

DR. JOSEPH L. JOHNSON, when he was Conference chairman for 1961, proposed the formation of local

Imhotep Committees composed in the several localities throughout the country of representatives of constituent units of each of the sponsoring organizations, the NMA, the NAACP and the NUL.* There was uniformly favorable response to this plan and the Imhotep Committee of Baltimore, Md. would appear to be still intact.

Accordingly, for the 1962 Conference Dr. Rann has asked the formation of local Imhotep Committees in as many communities as possible. Each constituent society of the National Medical Association, through its Council on Medical Education and Hospitals, each branch of the NAACP, through its National Health Committee, and each branch of the NUL, through MR. JULIUS THOMAS, its director of industrial relations has been asked to designate two representatives to a local Imhotep Committee. Because there are more NAACP branches than either NMA constituent societies or NUL branches, there will be some local committees which would have to be drawn entirely from NAACP branches. It is expected that such branches would expand their committees to a membership of six and balance them between lay and professional representation.

REGIONAL COORDINATORS

To act as additional resource persons and area stimulators and coordinators, Dr. Rann as asked the following to act as regional coordinators for their particular states:

Alabama, ROBERT C. STEWART, M.D.; Arizona, LOWELL C. WORMLEY, M.D.; Arkansas, TORRENCE J. COLLIER, M.D.; California, JULIUS W. HILL, M.D.; Colorado; CLARENCE HOLMES, D.D.S.; Connecticut, J. LUCIAN CARWIN, M.D.; Delaware, WAYMAN R. COSTON, M.D.; Florida, FRED W. ALSUP, M.D.; Georgia, ALLEN N. BROWN, M.D.; Iowa, WILLIAM H. HARPER, M.D.; Illinois, ROBERT G. MORRIS, M.D.; Indiana, WILLIAM BASS, M.D.; Kansas, A. PORTER DAVIS, M.D.; Kentucky, MAURICE F. RABB, M.D.; Louisiana, AUGUST C. TERRENCE, M.D.; Massachusetts, JOHN J. GOLDBERRY, M.D.; Maryland, EMERSON C. WALDEN, M.D.; Maine, COL. VANCE H. MARCHBANKS, M.D.; Michigan, LIONEL F. SWAN, M.D.; Minnesota, WILLIAM D. BROWN, M.D.; Mississippi, ALBERT B. BRITTON, M.D.; Missouri, SAMUEL U. RODGERS, M.D.; Nebraska, WILLIAM W. SOLOMON, M.D.; New Hampshire, ALBERT C. JOHNSON, M.D.; New Jersey, JOHN L. PINDERHUGHES, M.D.; New York, CHARLES A. P. BROWN, M.D.; Ohio, KENNETH W. CLEMENT, M.D.; Oklahoma, GRAVELLY E. FINLEY, M.D.; Oregon, DENORVAL UNTHANK, M.D.; Pennsylvania, EDWARD S. COOPER, M.D.; Rhode Island, SAMUEL C. MCKINNEY, M.D.; South Carolina, DEWEY M. DUCKETT, M.D.; Tennessee, WILLIAM O. SPEIGHT, M.D.; Texas, EDWARD D. SPROTT, M.D.; Washington, JOHN HENRY, M.D.; Wisconsin, GEORGE H. LANE, M.D.; West Virginia, PEYTON R. HIGGINBOTHAM, M.D.

* v. this *Journal*, v. 53, pp. 83, 198, 1961.

HILL-BURTON "SEPARATE BUT EQUAL" PROVISION UNCONSTITUTIONAL

Interested attorneys have advised the *Journal* that racial discrimination in hospitals can be fought effectively in court actions based on Federal Government involvement in hospital activities. Since 1944, hundreds of millions of Federal dollars have been used under the Hill-Burton Act to build state, city, county and private non-profit hospitals throughout the United States.

This Act has as its main purpose, the development of programs for and assistance in construction of such public and private non-profit hospitals as will afford the necessary physical facilities for furnishing adequate hospital, clinic and similar services to *all* the people. While the Act, adopted in 1944, requires non-discriminatory provision of facilities by participating hospitals, it allows an exception if "separate but equal" facilities are provided.

Recent developments in civil rights law indicate strongly that this "separate but equal" clause is unconstitutional—violating the due process clause of the 5th Amendment.

It has been a long established law that the 14th Amendment to the Constitution guarantees against discrimination on the basis of race by state governments.[1] The fiction of "separate but equal," however, made this guarantee all but meaningless in many vital areas until the historic *Brown* v. *Board of Education* decision in 1954 declared "separate but equal" state-operated schools unconstitutional.[2] At the same time, the Supreme Court declared that Federally operated "separate but equal" schools violated the due process clause of the 5th Amendment.[3] Thus were the precedents established for abolishing racial segregation in all federally supported activities.

While the major progress has been in the field of education, the principles of the *Brown* case are slowly being extended to the field of housing. It is clear that government operated housing projects may not discriminate or segregate on the basis of race.[4] The same would undoubtedly hold true for government operated hospitals. The legal problems arise, however, when the activity (housing, hospitals, restaurant, etc.) is private and the government is involved in some non-obvious way.

Examples of such non-obvious federal involvement are the FHA and VA financing programs for private housing developments. Recently a California lower court[5] held that a home builder who elects to avail himself of the mortgage insurance systems of the FHA and VA becomes an instrumentality to further the objectives and effectuate the purposes of this national housing legislation. Having made that choice, he is bound by the Fifth Amendment and may not discriminate or segregate on a racial basis in the administration of this act. The private developer had argued to the court that Congress had rejected efforts to insert anti-discrimination provisions in the act and thus expressed an intention to allow segregation. The court replied that the fundamental law of this country